

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **724**
Registrar's No. **724**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH: **St. Louis, Mo.**
(a) County.....
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **City Sanitarium**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **33 yrs. 5 mo. 3 days**
(Specify whether
In this community **55 years**
years, months or days)

3. (a) PRINT FULL NAME **Mary L. Sheehan**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Cornelius Sheehan** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **5-15-1866**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 8 5 hr. min.

9. Birthplace **Unknown** **Ireland**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business **Domestic**

12. Name **Frank Ford**

13. Birthplace **Unknown** **Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Margaret Castlianna**

15. Birthplace **Unknown** **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Deaf Zanto**

(b) Address **5400 Grand**

17. (a) **Burial** (b) Date thereof **Jan 24 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **H. Hoffmeister, Sub. L. Ho.**

(b) Address **7814 S. Broadway, St. Louis, Mo.**

19. (a) **JAN 23 1941** (b) **J. J. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
St. Louis
(c) City or town **1317**
(If outside city or town limits, write "RURAL")
(d) Street No. **2927 Macklind Ave.**
(If rural, give location) **9**
(e) If foreign born, how long in U. S. A. **95** years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan.** day **20**
year **1941** hour **1:00** minute **P.M.**

21. I hereby certify that I attended the deceased from.....
....., 19....., to....., 19.....;

that I last saw him alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion 1-18-41**

Due to **Arteriosclerosis 7-1-39x**
Senility 7-1-39x

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy **No.**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?.....
(Specify type of place) (e) Means of injury **9**

23. Signature **Robert H. Howe** (M. D. or other) **M.D.**

Address **5400 Grand** Date signed **1/21/41**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Edwin H. Leiberger

Licensed Embalmer No. *4049*

P. O. Address.....

6464 Clipperton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.